CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of: **Deborah Heart and Lung Cancer**	**Claim for Payment Determination for Cost Reporting Period(s) Ending: 12/31/2011**
Provider **vs.**	
Blue Cross Blue Shield Association	**Review of:** **PRRB Dec. No. 2014-D7** **Dated: April 15. 2014**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The Centers for Medicare (CM) submitted comments, requesting that the Administrator reverse the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the Provider. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

Issue and Board's Decision

The issue is whether CMS improperly denied the Provider's request to be reclassified as a rural hospital under section 1886(d)(8)(E) of the Social Security Act and 42 CFR 412.103.

The Board found that CMS improperly denied the Provider's application for reclassification because the Provider satisfied the criteria for reclassification as a rural hospital under section 186(d)(8)(E) of the Act and 42 CFR 412.103. The Board found that the Provider's reclassification is effective July 18, 2011, the date it submitted its application for reclassification.

The Board found that CMS improperly denied the request as the Provider is located in a State without a rural area. The Board found that the Provider qualifies for reclassification as a rural hospital by its location in a rural census tract of an MSA (Metropolitan Statistical Area). A hospital is entitled to be treated as if it is a rural hospital if it is located in a rural census tract of an MSA as determined by the most recent version of the Goldsmith Modification. The most recent Goldsmith Modification is defined by the Rural–Urban Commuting Area (RUCA) codes as determined by the Health Resources and Services Administration (HRSA) Office of the Rural Health Policy. CMS and the HRSA Office of Rural Policy consider all census tracts with RUCA codes from 4-10 as rural. The Provider is located in a Rural–Urban Commuting Area census tract assigned with a code of 4 and therefore demonstrates reclassification as a rural hospitals.

The Board found that section 1886(d)(8)(E) of the Social Security Act does not require the existence of an actual "rural area" in a State as a condition precedent to reclassification. The Board concluded that the statute does not forbid hospitals in States with no rural areas from reclassification. Because the hospital is located in a rural census tract as determined under the most recent Goldsmith Modification, it is qualified for reclassification. The Board found that the CMS attempt to limit the Provider's ability to reclassify as a rural hospital because it is located in an Metropolitan Statistical Area (MSA) of a State comprised solely of MSAs contravenes its own regulations and Congress' and its own regulatory determination to rely on RUCA codes to define and identify "rural" MSAs.

The Board determined that the legislative history of section 1886(d)(8)(E) of the Act demonstrates Congress' intent to broadly permit hospitals to reclassify as rural and shows no intent to bar New Jersey hospitals from reclassification. The Board distinguished the language at 42 CFR 412.102 and 42 CFR 412.103 as significant, along with the MGCRB distinction. Finally the Board rejected the Intermediary's discussion of certain attributes of New Jersey as not set forth as criteria for reclassification.

Summary of Comments

CM submitted comments requesting that the Board's decision be reversed. CM explained that section 1886(d)(8)(E)(i) states that: "the Secretary shall treat the hospital as being located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located." Because the statute allows for reclassification to the rural area of the State in which the hospital is located and there is no rural area in the State of New Jersey there is no rural area in the state where the hospital can be reclassified following the plain language of the statute. The Board presents an alternative reading of the statute. Even if this alternative reading was permissible interpretation of section 1886(d)(8)(E) of the Act, it is not

a formulation that CMS has adopted in the regulations. Therefore, the Board erred in its conclusion and the decision should be reversed.[1]

The Provider requested that the Administrator either decline to review, or affirm the Board's decision, in this case. The Provider stated that it had requested rural status under 42 CFR 412.103 in order to be eligible for Medicare Dependent Hospital or MDH status. CMS denied the Provider's request solely on the basis that it is located in a State without any "rural" areas. The parties agreed that the Provider otherwise meets the criteria in that it is located in a census tract that is classified as rural under the most recent version of the Goldsmith Modification, i.e., the RUCA codes. Under the statute at section 1886(d)(8)(E) of the Act and 42 CFR 412.103, a hospital meeting this single criterion is eligible for reclassification. There is no indication in the statute and legislative history and its implementing regulation are devoid of any indication that hospitals in States without rural areas should be ineligible for reclassification. Pursuant to the unambiguous terms of the statute, the Board properly found that as the hospital is located in a rural census tract as determined under the most recent Goldsmith Modification it is qualified for reclassification. The Administrator must affirm as it is consistent with clear congressional intent.

The Board properly found that being located in a State with a rural area is not a condition precedent to reclassification. The statute creates a fiction "as being" rural even though the hospital does not in fact have that characteristic. This is consistent with the intermediary witness who agreed that nowhere in the statute is a hospital in a State without a rural area forbidden reclassification.

The Provider said the Board also properly determined that this reading is consistent with the regulation and preamble language. A reversal would also be contrary to the plain text of the regulation. The Provider maintained that the issue is limited to the Provider's reclassification as rural However, the Provider maintained that, through this appeal, even if the Provider is reclassified as a rural hospital New Jersey would continue to be an all-urban State as one with no rural areas or rural hospitals under 42 CFR 412.64(h). While the decision permits the Provider to be reclassified as a rural hospital, it does not establish a rural area in New Jersey. (Decision at 10, existence of rural area not condition precedent to reclassification) (Decision at 16, reclassification treats hospital as if located in rural area).

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[1] A letter in support of the Hospital's position and requesting that the Board's decision be upheld was submitted by Congressman Jon Runyan. In addition, a letter in support of the Hospital's position and requesting that the Board's decision be upheld was submitted by Senator Robert Menendez, Senator Cory Booker, Congressman Bill Pascrell, and Congressman Jon Runyan.

Discussion

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

The Social Security Amendments of 1965[2] established Title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[3] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[4] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[5] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[6] This provision added section 1886(d) of the Act and established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[7] These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimburse their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. Thus, hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based on diagnosis related groups or DRG subject to certain payment adjustments.

The payments for IPPS hospitals can be affected by where a hospital is geographically located. For example, the wage index values, a component of the payment, is related to

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[2] Pub. Law No. 89-97.
[3] Sections 1811-1821 of the Act.
[4] Section 1831-1848(j) of the Act.
[5] Under Medicare, Part A services are furnished by providers of services.
[6] Pub. L. No. 98-21.
[7] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

a hospital's geographical location.[8] In addition, classification as a rural or urban hospital can affect disproportionate share payments and determine eligibility for certain special payment status such as Sole Community Hospital (SCH), Medicare Dependent Hospital (MDH), Rural Referral Center (RRC), and Critical Care Hospital (CAH). The statute at section 1886(d)(2) sets forth the definition of "urban" and "rural" for purposes of payment stating that:

> (D) COMPUTING URBAN AND RURAL AVERAGES.—
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> For purposes of this subsection, ….; the term "urban area" means an area within a Metropolitan Statistical Area (as defined by the Office of Management and Budget) or within such similar area as the Secretary has recognized under subsection (a) by regulation; …. and the term "rural area" means any area outside such an area or similar area.
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Consistent with the statute, the regulation provides at 42 CFR §412.64(b), the definition of urban and rural for purposes of prospective payment rates that:

> (b) Geographic classifications. (1) For purposes of this section, the following definitions apply:
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> (ii) The term urban area means—
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> (A) A Metropolitan Statistical Area or a Metropolitan division (in the case where a Metropolitan Statistical Area is divided into

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[8] Section 1886(d)(2)(H) provides that: "ADJUSTING FOR DIFFERENT AREA WAGE LEVELS.—The Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage–related costs, of the national and regional DRG prospective payment rates computed under subparagraph (G) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level."

> Metropolitan Divisions), as defined by the Executive Office of Management and Budget; or
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> (B) The term rural area means any area outside an urban area.

Congress has provided certain processes by which a Hospital may be considered as being located in another area. For example, under section 1886(d)(8)[9] of the Act, a hospital in an outlying county may be treated as if being part of an existing urban area under certain conditions. Section 601(g) of the Social Security Amendments of 1983[10] classifies hospitals in certain New England counties as belonging to the

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[9] Regarding outlying counties at 42 CFR 412.63(b)(3)(i): "For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the FEDERAL REGISTER on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244."

[10] Pub. Law 98-21. Section 601(g) of the Social Security Amendments of 1983 provides that: "In determining whether a hospital is in an urban or rural area for purposes of section 1886(d) of the Social Security Act, the Secretary of Health and Human Services shall classify any hospital located in New England as being located in an urban area if such hospital was classified as being located in an urban area under the Standard Metropolitan Statistical Area system of classification in effect in 1979." Pursuant to 42 CFR 412.63(b)(3)(ii) the "hospitals in the following New England counties, if not already located in an urban area, are deemed to be located in urban areas under section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21, 42 U.S.C. 1395ww (note): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island."

adjacent existing urban area.[11] Under section 1886(d)(10) of the Act,[12] a hospital or group of hospitals in a county may request reclassification to another existing labor market area if certain conditions are met. Importantly, in each of these situations, where a hospital is treated as being located in another area, any so called "fiction" is limited to treating the hospital as being located in another area for purposes of IPPS payments and for certain special status considerations. However, the "fiction" does not extend to creating a fictional "area" to which the hospital is being reclassified.

Further, where an urban area in which a hospital is located is redesignated to rural because of changes by OMB (per census data changes, etc.), section 1886(d)(8)(A)[13]

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[11] 79 Fed. Reg. 27978, 28382 (May 15, 2014) ("Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21) designated hospitals in certain New England counties as belonging to the adjacent urban area."); (55 Fed. Reg. 15150, 15166 (April 20, 1990) ("Also, section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21) designated hospitals in certain New England counties as belonging to the adjacent New England Metropolitan County.")

[12] Section 1886(d)(10) provides that: "The Board shall consider the application of any subsection (d) hospital requesting that the Secretary change the hospital's geographic classification for purposes of determining for a fiscal year-- … (II) the factor used to adjust the DRG prospective payment rate for area differences in hospital wage levels that applies to such hospital under paragraph (3)(E)." Under section 1886(d)(10((D)(i), the Secretary was directed to "publish guidelines to be utilized by the Board in rendering decisions on applications submitted under this paragraph, and shall include in such guidelines the following: (I) Guidelines for comparing wages, taking into account (to the extent the Secretary determines appropriate) occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified. (II) Guidelines for determining whether the county in which the hospital is located should be treated as being a part of a particular Metropolitan Statistical Area. (III) Guidelines for considering information provided by an applicant with respect to the effects of the hospital's geographic classification on access to inpatient hospital services by medicare beneficiaries. (IV) Guidelines for considering the appropriateness of the criteria used to define New England County Metropolitan Areas." See also the MGCRB process for reclassification promulgated at 42 CFR 412.230, et seq..

[13]Section 1886(d)(8)(A) provides that: "In the case of any hospital which is located in an area which is, at any time after April 20, 1983, reclassified from an urban to a rural area, payments to such hospital for the first two cost reporting periods for which such reclassification is effective shall be made as follows: (i) For the first such cost reporting period, payment shall be equal to the amount payable to such

and 42 CFR 412.102 provide for a transition period for the hospital payments.[14] In that instance, it is the area that is redesignated by OMB as a rural area and, in order to soften the impact, CMS provides for a transitional payment period. In that instant, again, there is no fictional labor market area being created, rather CMS revised the heading to distinguish that, in 42 CFR 412.102, it is the existing area to which CMS is referring that has been redesignated as rural due to the OMB's geographical resdesignation. Thus, the "heading change" for 42 CFR 412.102[15] was to clarify that this section

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hospital for such reporting period on the basis of the rural classification, plus an amount equal to two-thirds of the amount (if any) by which— (I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds; (II) the amount payable to such hospital for such reporting period on the bass of the rural classification.(ii) For the second such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to one-third of the amount (if any) by which—(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds; (II) the amount payable to such hospital for such reporting period on the basis of the rural classification."

[14] The regulation at 42 CFR 412.102 provides that: "Special treatment: Hospitals located in areas that are reclassified from urban to rural as a result of a geographic redesignation. Effective on or after October 1, 1983, a hospital reclassified as rural, as defined in subpart D of this part, may receive an adjustment to its rural Federal payment amount for operating costs for two successive fiscal years." In promulgating this provision, the Secretary explained that: As CMS explained: "Section 1886(d)(8) of the Act, as added by section 2311(c) of Pub. L. 98-369, provides for an adjustment to the payment amounts for hospitals reclassified from urban to rural after April 20, 1983. Effective with hospital cost reporting periods beginning on or after October 1, 1983, a hospital that loses its urban status, as a result of an EOMB [Executive Office of Management and Budget] redesignation occurring after April 20, 1983, may qualify for special consideration by having its rural Federal rate phased in over a two-year period (§412.102)." (51 Fed Reg. 19970 (June 3, 1986)(Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1987 Rates).

[15] The provision at 42 CFR 412.102 does not involve MGCRB reclassification, which is controlled by 42 CFR 412.230, *et seq*.

involves the redesignation of the geographical area from urban to rural as distinguished from the reclassification of a hospital from urban to rural.[16]

In addition to the foregoing "reclassification" processes, Section 401(a) of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA)[17] amended section 1886(d)(8) and added new paragraph (E). Section 1886(d)(8)(E) of the Act provides that:

> (E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary shall treat the hospital as being located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located.
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> (ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:
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> (I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally

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[16] The heading was changed from "Special treatment; Hospitals reclassified as rural" to "Special treatment: Hospitals located in areas that are reclassified from urban to rural as a result of a geographic redesignation." 65 Fed Reg. 47026, 47031 (Aug 1, 200)("E. Changes in the Regulations. "We are adding a new § 412.103 to incorporate the provisions on the urban to rural reclassification options set forth in section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106-113, and the application procedures for requesting reclassification. A formula for transition payments to hospitals located in an area that has undergone geographic reclassification from urban to rural is set forth in section 1886(d)(8)(A) of the Act and implemented in regulations at §§ 412.90 and 412.102. We are revising existing §§ 412.63(b)(1) and 412.90(e) and the title of §412.102 to clarify the distinction between hospital reclassification from urban to rural and the geographic reclassification (or redesignation) of an urban area to rural.")

[17] Pub. Law 106-113.

> published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).[18]
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The regulation at 42 CFR 412.103 specifies that:

> Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.
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> (a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
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> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural-Urban Commuting Area codes, as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration, which is available via the ORHP Web site at: http://www.ruralhealth.hrsa.gov or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9A-55, Rockville, MD 20857.

Notably, under 42 CFR 412.103, an urban hospital that reclassifies as a rural hospital under 42 CFR 412.103 is considered rural for all IPPS purposes. CMS adopted the following policies, with respect to the impact of 42 CFR 412.103 reclassifications on the computation of the wage index:

> In cases where hospitals have reclassified to rural areas, such as urban hospitals reclassifying to rural areas under 42 CFR 412.103, the hospital's wage data are: (a) included in the rural wage index calculation, unless doing so would reduce the rural wage index; and

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[18] The Senate version of the amendment omitted the language “of the State in which the hospital is located” which was not adopted in the final version enacted into law.

> (b) included in the urban area where the hospital is physically located. The effect of this policy, in combination with the statutory requirement at section 1886(d)(8)(C)(ii) of the Act, is that rural areas may receive a wage index based upon the highest of: (1) Wage data from hospitals geographically located in the rural area; (2) wage data from hospitals geographically located in the rural area, but excluding all data associated with hospitals reclassifying out of the rural area under section 1886(d)(8)(B) or section 1886(d)(10) of the Act; or (3) wage data associated with hospitals geographically located in the area plus all hospitals reclassified into the rural area. [19]

Finally, the Secretary explained that:

> Hospitals that are geographically located in States without any rural areas are ineligible to apply for rural reclassification in accordance with the provisions of 42 CFR 412.103.[20]

In response to a commenter, the Secretary stated that:

> Comment: One commenter noted that CMS did not propose any amendments to §412.103, but requested that CMS retract the statement that hospitals that are geographically located in States

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[19] 76 Fed. Reg. 51476 (Medicare Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and FY 2012 Rates) (August 18, 2011)

[20] 79 Fed. Reg. 27978-01 (May 15 2014)(Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates); 78 Fed. Reg. 50496 (August 19, 2013)(Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates); 78 Fed. Reg. 27486 (May 10, 2013)(Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates); 77 Fed. Reg. 53258 (August 31, 2012)(Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates); 77 Fed. Reg. 27870 (May 11, 2012)(Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates.)

> without any rural areas are ineligible to apply for rural reclassification pursuant to 42 CFR 412.103; the commenter believed that this statement is a change in policy. The commenter believed that the statute and regulations permit a hospital in an all-urban State to be treated as if it were located in a rural area, and that no actual rural area in the State is necessary for such reclassification. Response: We disagree with commenter's request, and maintain our position that hospitals that are geographically located in States without any rural areas are ineligible for §412.103 reclassification. This is consistent with the statute and CMS' longstanding policy, and we did not propose any changes to this policy.[21]

Generally, under the rules of statutory construction, all words are to be given effect in a statute. The plain language of the statute at section 1886(d)(8)(E) allows a hospital that meets certain criteria to be reclassified to "the rural area (as defined in paragraph (2)(D)) of the State in which the Hospital is located." CMS has determined that the language authorizing a hospital to be reclassified to "the rural area…of the State in which it is located", means that, where a State does not have a "rural area" (as defined by paragraph (2)(D)), such a hospital is ineligible for reclassification.

While the Provider maintains that "the rural area" can be a fictional rural area, such a reading, *inter alia*, makes surplus the foregoing phrases: "(as defined in paragraph (2)(D))" and "of the State where the Hospital is located." In addition, the use of the term "the rural area" is consistent with the fact that a State with areas outside the urban area will have one ("the") rural area which may be made up of various counties.[22] Contrary to the Provider's contention that there can be more than one "rural area" in a State, "the" rural area is consistent with the identification of "the" rural area in a State under OMB rules and methods as required under section 1886(d)(2)(D) and adopted by CMS.[23]

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[21] 78 Fed. Reg. 50496 (August 19, 2013) (Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates).

[22] A State will only have one rural area made up of "any area outside an urban area in a State." The Provider suggested that a State may have more than one "rural area" which is incorrect for IPPS payment purposes.

[23] If the statute was only granting "rural" status fiction (for example, for purposes of qualifying for MDH status) the term "rural area" would not be qualified by the

While the Provider fails to give effect to certain phrases in the statute, it conversely argues that it is significant that Congress omitted that hospitals in a State without a rural area are ineligible for reclassification. However, the plain language of the statute clearly indicates the scope of the statute as excluding such hospitals from classification as rural. When each word is given effect, such a prohibition expressly prohibiting Hospitals in States without rural areas is surplus and unnecessary language.

Further, the Provider's interpretation requires the creation of a fictional New Jersey rural area in contravention to the controlling provisions defining geographical areas for purposes of IPPS payment. Under the 42 CFR 412.103 provision, a Hospital is reclassified for all IPPS payment purposes, including the wage index. Under the Provider's scenario, CMS would be required to compute a wage index for a labor market area ("rural" New Jersey) that does not exist under the OMB rules and designations adopted by CMS in accordance with the statute.[24] Under the OMB geographical areas adopted by CMS there is no rural New Jersey area. Historically, both Congress and CMS, when allowing for reclassification of hospitals across all of the various provisions have provided for reclassifications to areas as designated by OMB and adopted by CMS.[25] Under the various foregoing reclassification processes examined, neither Congress, nor CMS has provided for reclassification to a fictional area, nor does the Provider point to any specific authority for CMS to reclassify a hospital to an area not recognized as "rural" under the OMB standards adopted by CMS for IPPS payment.[26]

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phrase "(as defined by paragraph (2)(D)) in the State in which the Hospital is located."

[24] The Senate version of the amendment omitted the language "of the State in which the hospital is located" which was not adopted in the final version enacted into law and instead included this language.

[25] The fact that the regulation setting forth this process does not list, as an element for reclassification at 42 CFR 412.103, the requirement that a hospital be located in a State with a rural area in order to be reclassified as rural, is not an omission of a "criteria" or "condition precedent." CMS does not reclassify hospitals under any process to non-existent fictional areas. In this instance, the provision implements the process for reclassification as a rural hospital, which requires a rural area to which the hospital can be reclassified.

[26] That Congress or CMS might create such a fiction is also problematic in light of the annual process under which the wage index is constructed for the identified

The Board also pointed to CMS' statement, when discussing the intersection of the section 1886(d)(10) reclassifications under the MGCRB process and the section 1886(d)(8)(E) reclassification as support for its interpretation. CMS stated that: "it is appropriate to distinguish between hospitals that are reclassified as rural under section 1886(d)(8)(E) of the Act and hospitals that are geographically rural."[27] However, this statement does not support the contention that section 1886(d)(8)(E) recognizes a fictional reclassification to a non-existent rural area. Rather, the intersection of these two provisions means that, for example, the hospital cannot use the section 1886(d)(8)(E) reclassification status as a basis for a second section 1886(d)(10) reclassification. It means, among other things, to meet the MGCRB mileage criteria, an urban hospital reclassified as rural under section 1886(d)(8)(E) of the Act, when filing an individual application under the proximity rules, is not treated as a hospital *geographically located in a rural area* as it is in fact located in an urban area. Consistent with that treatment, a rural hospital reclassified as urban under section 1886(d)(10) at the time it files its application under the MGCRB process does not now have to meet the urban mileage criteria, but rather the application is evaluated pursuant *to its geographical location as rural*. A hospital's reclassification status under either process at the time it files its application does not mean the hospital uses the "reclassification" status to meet the MGCRB criteria. Whether a hospital at the time of its MGCRB application is reclassified under section 1886(d)(8)(E), or section 1886(d)(10), a hospital is to meet the appropriate criteria based on its actual geographical location and under neither processes can a hospital hold simultaneous reclassifications for the same period..

The Provider also points to the definition of an "all-urban state" under the regulation to support its argument. The definition of an all-urban State in part arises as a result of the Balanced Budget Act of 1997 which created a wage index exception that requires any Core Based Statistical Area[28] (CBSA) wage index in a

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actual labor market areas. The reclassification under 42 CFR 412.102 is for all purposes including the wage index.

[27] 65 Fed. Reg. 47088 (August 1, 2000).

[28] In the Federal fiscal year 2005 Hospital Inpatient Prospective Payment System Rule, CMS discussed and adopted changes to the metropolitan statistical area (MSA) criteria used to define hospital labor market areas based on the new Core-Based Statistical Areas or CBSA definition announced by the United States Office of Management and Budget (OMB) on June 6, 2003 which are based on 2000 Census data. See, e.g. 69 Fed. Reg. 28196, 28248-52, 28321 (May 18, 2004); 69 Fed. Reg. 48916, 49026–49034, 49077 (August 11, 2004). Technically, the term

State be equal to or greater than the State-wide rural wage index in that State. The rural floor exception was extended to States without rural areas and an imputed rural floor was created for those States, such as New Jersey. While not at issue in this case whether this particular rural designation for this hospital would affect the imputed rural floor for New Jersey hospitals, the Provider points to the definition of an all-urban State for support of its interpretation of 42 CFR 412.103. The regulation at 42 CFR 412.63(i)(5) defines the all-urban State as follows:

> (5) An all-urban State is a State with no rural areas, as defined in this section, or a State in which there are no hospitals classified as rural. A State with rural areas and with hospitals reclassified as rural under §412.103 is not an all-urban State.

The Provider argues that the definition of an "all-urban State" supports that such hypothetical areas in fact are anticipated. The Provider contends that the sentence: "A State with rural areas and with hospitals reclassified as rural under §412.103 is not an all-urban State" would not otherwise be needed. However that sentence is aligned with the stated policy that a State with no rural areas and a State with rural areas in which no hospitals are classified for payment purposes are both considered all urban States. This definition of an all-urban State is consistent with the fact that CMS does not allow for reclassification of urban hospitals in States with no rural area.[29]

The Provider also suggests that the reclassification as rural under 42 CFR 412.103 will not impact the all-urban status of the State and the imputed rural floor applied to hospitals in that State. However, as CMS as explained:

"CBSA" refers collectively to both metropolitan statistical areas and micropolitan areas. However, for purposes of IPPS payment, the term CBSA is referring to MSA and the two terms are used interchangeably.

[29] The Provider contends that this reclassification in this case would involve a fictional rural area and, therefore, will not change the imputed rural floor in the State of New Jersey. In order to fit the Provider's interpretation and contrary to the plain language, the Provider suggests CMS distinguishes between two types of rural floor reclassifications under 42 CFR 412.103 for purposes of computing the rural floor: those where there is in fact a rural area in the State to which a hospital is being reclassified and those where a hospital is reclassified to a fictional rural area in a non-rural State. The fact that the language of the regulation does not support this contention is consistent with the lack of evidence that either Congress or CMS ever intended to reclassify hospitals to hypothetical/fictional rural areas under 42 CFR 412.103.

> We note that if a State has a hospital reclassified as rural under § 412.103, the State will be considered to have IPPS hospitals located in rural areas because, in this case, the reclassified hospital is treated as being located in a rural area in accordance with section 1886(d)(8)(E) of the Act. This policy also accords with how we defined an "all-urban State" under § 412.64(h)(5) of the regulations, which specifies that "A State with rural areas and with hospitals reclassified as rural under §412.103 is not an all-urban State."[30]

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[30] 72 Fed. Reg. 47130 at 47322 (August 22, 2007)(Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates Wednesday) CMS also explained the impact of having a hospital reclassified as rural under 42 CFR 412.103, where previously there were no hospitals classified as rural in the existing rural area of the State in Massachusetts as follows: "Response: With respect to the impact on payment for Massachusetts hospitals from discontinuing the imputed rural floor, we note that an urban hospital applied to be redesignated as rural under 42 CFR § 412.103. Therefore, as this hospital was approved for an urban-to-rural designation, it is now considered to be rural for purposes of its IPPS payments. Therefore, its wage index will set the rural floor….". 72 Fed. Reg. 47130- (August 22, 2007)(Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates)

In addition, with respect to the rural floor and the "hold harmless" provisions, CMS stated: "One commenter questioned whether Massachusetts should indeed lose its imputed floor due to a hospital acquiring an urban-to-rural reclassification under 42 CFR 412.103. The commenter noted that the "hold harmless" provisions (in section 1886(d)(8)(C) of the Act) protect a State's rural floor from being unduly reduced due to the effects of reclassification/redesignation. The commenter believed the imputed floor should be treated in a similar manner. Response: As discussed in section III.I.2. of the preamble of this final rule with comment period, we have a policy that precludes an urban-to-rural redesignation under §412.103 from reducing the rural wage index. However, when no hospitals are geographically located in a rural area, or when no rural hospitals' wage data can be used to calculate the rural wage index, there is no rural wage index. Therefore, the urban-to-rural redesignation is not reducing the rural wage index. Rather, the data of the redesignated hospital establish the rural wage index. The imputed floor was intended to be applied in states where a rural floor could not be calculated and is rendered moot when an urban-to-rural redesignation within a State establishes a situation where a rural floor can be calculated. Therefore, we disagree with this commenter and are calculating a rural wage index for Massachusetts based on the average hourly wage for the one hospital that has been redesignated as rural. This

In conclusion, the Administrator finds that CMS properly denied the Hospital's request to be reclassified under section 1886(d)(8)(E) of the Social Security Act and the regulation at 42 CFR 412.103, based on a finding that the State in which the Hospital is located, New Jersey, does not have a rural area.[31]

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rural wage index will become the rural floor for Massachusetts hospitals for FY 2008." 72 Fed. Reg. 47130 at 47323 (August 22, 2007)(Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates Wednesday).

[31] Finally, the Board rejected the Intermediary's discussion of certain attributes of New Jersey. However, it appeared the Intermediary was not attempting to highlight these characteristics as an alternative standard for qualification, but rather to explain how the prohibition of reclassification for hospital in all urban State was not contrary to the intent of the statute.

Decision

The decision of the Board is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 6/18/14 /s/

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services